A Guide For People With Medicare

Choosing a Medicare Health Plan

Developed jointly by the
Centers for Medicare & Medicaid Services
and the
Agency for Healthcare Research and Quality

Centers for Medicare & Medicaid Services

This booklet, ***Choosing a Medicare Health Plan***, is one of a new series of booklets for people who have Medicare. Other titles include ***Choosing a Doctor, Choosing Treatments, Choosing a Hospital***, and ***Choosing Long-Term Care***, which will be available in late 2001. Each booklet can help you to make health care choices. Use this booklet to help you decide how to get your Medicare health care.

To get copies of this booklet in print (English or Spanish) or Braille, call 1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired.

CONTENTS

This Guide has a lot of tips and questions to help you make the health plan choice that is right for you. Get as much information as you can so you can make your best choice. But it is not necessary, or even possible, for every person to do everything this Guide suggests. Do as much or as little as you feel comfortable with.

A note about the symbols used in this booklet:

 means a mailing address.

 means a telephone number.

 means a number for TTY or TDD, text telephones for people with hearing and speech impairments.

 means a computer Web site address.

If you do not have a computer, your local library or senior center may be able to help you find information on their computers.

How This Booklet Can Help You

You may be new to Medicare. Or you may be thinking about changing how you get your Medicare health care. This booklet can help you make that choice.

Choosing a Medicare health plan is a very important decision. It determines how you get your health care. Your health plan choice affects:

- **Cost**—how much you will pay.
- **Doctor choice**—who will care for you (doctors and other health care providers), and how much choice you will have.
- **Benefits**—what kind of care you will get (which services are covered), and if you get extra benefits, like prescription drugs, eye exams, hearing aids, or routine physicals.
- **Convenience**—where you will get your care (which hospitals, for example), and any rules you need to follow.
- **Quality**—how you will be cared for (the quality of care you get).

This booklet can help you choose a Medicare health plan that meets your needs. The basics you need to know are in the first section. The second section, which starts on page 25, has more details if you want them.

A Few Words About Medicare

Medicare offers you different ways to get your Medicare benefits. These different options are called Medicare health plans. Medicare health plans contract with and are managed by the Medicare program. How you get your health care in the Medicare program depends on which plan you choose. Depending on where you live, you may have more than one plan to choose from.

In 2002, Medicare offers the following types of Medicare health plans:

Original Medicare Plan (sometimes called fee-for-service)

Everyone with Medicare can join the Original Medicare Plan. This plan is available nationwide. Many people in the Original Medicare Plan also have a Medigap (Medicare Supplement Insurance) policy to help pay health care costs that this plan does not cover. (See page 32 for more about Medigap policies.)

Medicare + Choice Plans (pronounced "Medicare Plus Choice")

Medicare + Choice plans provide care under contract to Medicare. They may provide benefits like coordination of care or reduce out-of-pocket expenses. Some plans may offer additional benefits, such as prescription drugs.

There are two types of Medicare + Choice plans:

- Medicare managed care plans (like HMOs)
- Medicare Private Fee-for-Service plans

Medicare + Choice plans are available in many areas of the country. For information about the Medicare + Choice plans available in your area, look at www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227).

Medicare pays a set amount of money for your care every month to these private health plans. In turn, the Medicare + Choice plan manages the Medicare coverage for its members. If Medicare + Choice plans are available in your area, you can join one and get your Medicare covered benefits. You must have both Medicare Part A and Part B to join a Medicare + Choice plan for the first time. However, if you are in a Medicare + Choice plan and only have Part B, you can stay in your plan. By joining a Medicare + Choice plan, you can often get extra benefits, like prescription drugs. The Medicare + Choice plan may have additional rules that you need to follow. You may also have to pay a monthly premium for the extra benefits.

Medicare health plans are explained in more detail in Section 1.

It is important to know how you get your Medicare health care. To learn more about Medicare, look at your copy of the *Medicare & You* handbook (CMS Pub. No. 10050) which is mailed each fall to people with Medicare. You can order one from the Medicare Web site or by calling 1-800-MEDICARE.

 www.medicare.gov

 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

Other information about Medicare is also on the Medicare Web site. If you don't have a computer, your local library or senior center may be able to help you.

NOTES

Section 1

The Basics

Words You Should Know

Coinsurance. The percent of the Medicare approved amount that you have to pay after you pay the deductible for Part A and/or Part B (see page 9). In the Original Medicare Plan, the coinsurance payment is a percentage of the approved amount for the service (like 20 percent).

Copayment. In some Medicare + Choice plans, the amount you pay for each medical service, like a doctor visit. A copayment is usually a set amount you pay for a service. For example, this could be $5 or $10 for a doctor visit. Copayments are also used for some hospital outpatient services in the Original Medicare Plan.

Deductible (Medicare). The amount you pay for health care before Medicare begins to pay.

Premium. What you pay monthly for health care coverage to Medicare, an insurance company, or a health care plan.

Primary care doctor. A doctor (physician) who is trained to give you basic care. Your primary care doctor is the doctor you see first for most health problems. He or she makes sure that you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare managed care plans, you must see your primary care doctor before you see any other health care provider.

Referral. A written OK from your primary care doctor for you to see a specialist or get certain services. In many Medicare managed care plans, you need to get a referral before you get care from a specialist. If you do not get a referral first, the plan may not pay for your care.

Respite care. Short-term care given to a hospice patient by another caregiver, so that the usual caregiver can rest.

Service area. The area where a health plan accepts members. For plans that require you to use their doctors and hospitals, it is also the area where services are provided. A plan may require you to leave the plan if you move out of the plan's service area for more than a certain period of time.

Steps to Choosing a Medicare Health Plan

The six steps below can help you find a Medicare health plan that will meet your needs and give you good quality care.

Step 1. Learn about Medicare and the types of Medicare health plans.

Step 2. Find out which Medicare health plans are available in your area.

Step 3. Call the plans you are most interested in and ask questions.

Step 4. Find out how the plans rate in quality of care.

Step 5. Visit or call the doctors' offices where you would get your care.

Step 6. Review your plan choices every year in the fall.

Read on for more about each of these steps.

Step 1. Learn about Medicare and the types of Medicare health plans.

Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).

Medicare Part A (Hospital Insurance) helps pay for care in hospitals and skilled nursing facilities. It also pays for hospice and some home health care. Most people probably will not have to pay a premium for Medicare Part A because they paid Medicare taxes while they were working.

Medicare Part B (Medical Insurance) helps pay for doctors, outpatient hospital care, and some other necessary medical services that Part A does not cover, like some home health care. It starts to pay after you have paid the Part B deductible ($100 in 2001). Part B also pays for some services to help you stay healthy, such as diabetes monitoring, screening mammograms, and flu shots. Part B is voluntary. If you choose to have Part B, you must pay a monthly premium ($50 in 2001).

Some things are the same whether you get your health care coverage from the Original Medicare Plan, a Medicare managed care plan, or a Medicare Private Fee-for-Service plan:

- You are still in the Medicare program.
- If you have Medicare Part A, you get at least all the Medicare Part A covered services.
- As long as you pay the monthly Medicare Part B premium, you get at least all the Medicare Part B covered services. You must have Parts A and B to join a Medicare + Choice plan. If you are already in a Medicare managed care plan and have only Part B, you may stay in your plan.
- The Medicare program has standards to help you get quality health care.
- The Medicare program still pays for part of your health care.

Some things—like cost, choice of doctor, benefits, convenience, and quality—are different, depending on who provides your health care and whether you have the Original Medicare Plan, a Medicare managed care plan, or a Medicare Private Fee-for-Service plan. It is important to think about these things when choosing how to get your Medicare health care. Below is more information about these types of Medicare health plans. You can find more information about Medicare health plans in the *Medicare & You* handbook.

Original Medicare Plan (sometimes called fee-for-service)

The Original Medicare Plan is a "fee-for-service" plan. This plan, managed by the Federal Government, is available nationwide. If you are in the Original Medicare Plan, you use your red, white, and blue Medicare card when you get health care. If you are happy getting your care this way, you do not have to change. You will stay in the Original Medicare Plan unless you choose to join a Medicare + Choice plan.

In the Original Medicare Plan, you may go to any doctor, specialist, or hospital that accepts Medicare. Generally, a fee is charged each time you get a service. You pay a set amount for your health care (deductible) before Medicare pays its part. Then, Medicare pays its share, and you pay your share (coinsurance or copayment).

The Original Medicare Plan does not pay for or cover everything. To get extra coverage, you may also buy a Medigap policy. This type of policy only works with the Original Medicare Plan. For more information on Medigap policies, see page 32. You may also have or qualify for employer or union coverage, help from your State, TRICARE for Life (for military retirees and their spouses), or veterans' benefits. For more information on these other types of coverage, see page 33.

Medicare + Choice Plans (pronounced "Medicare Plus Choice")

Medicare + Choice plans currently include Medicare managed care plans and Medicare Private Fee-for-Service plans. Remember, you must have Medicare Part A and Medicare Part B to join a Medicare + Choice plan for the first time. If you are already in a Medicare managed care plan and

have only Part B, you may stay in your plan. You must continue to pay the Medicare Part B premium ($50 per month in 2001) and any additional premium the plan may charge.

- **Medicare managed care plans.** In most managed care plans, you can only go to certain doctors and hospitals that agree to treat members of the plan. Call the plan you are interested in to see which doctors are in the plan. Doctors can join or leave managed care plans at any time. If your doctor leaves your plan, ask your plan for the names of other plan doctors in your area.

  In a Medicare managed care plan, you may be able to get extra benefits, like prescription drugs. Generally, you need a referral to see a specialist (like a cardiologist), which means your primary care doctor tells you and the specialist it is OK for you to go.

  You may pay more if you get health care outside the service area of the plan, unless you have an emergency or need urgent care. The service area is where the plan accepts members and where you get services from the plan.

  Each year, the companies offering Medicare + Choice plans can decide to join, stay with, or leave Medicare.

- **Medicare Private Fee-for-Service plans.** If you join a Medicare Private Fee-for-Service plan, the private company, rather than the Medicare program, decides how much it pays, and how much you pay, for the services you get. You can go to any doctor or hospital that accepts the terms of the plan's payment.

  The private company provides health care coverage to people with Medicare who choose this plan. The private company pays a fee for each doctor visit or service you get, and you may also pay a fee.

  You may be able to get extra benefits, like coverage for additional days in the hospital. The private company may have a "pre-authorization" requirement. For example, it may require that you tell the plan of any planned inpatient hospital stays.

You may pay more if the plan lets doctors, hospitals, and other providers bill you more than the plan pays for services. If this is allowed, there may be a limit to what they can charge, and you must pay the difference.

For more information about a Medicare + Choice plan, call the plan.

Choosing the right health coverage is an important—but sometimes difficult—decision. The new "Medicare Personal Plan Finder" helps you narrow down your Medicare health plan choices and choose the plan that's best for you! You can also get important information about special programs that might help you pay health care costs that Medicare doesn't cover.

You can get this information two ways:

- Visit www.medicare.gov on the Web for fast results. Select "Medicare Personal Plan Finder."
- Call 1-800-MEDICARE (1-800-633-4227). Select option "0." A customer service representative will help you. You will get your results in the mail within 3 weeks.

You will need to answer some simple questions, including:

- What parts of Medicare you have (Part A and/or Part B).
- Your age.
- What your general health is.

If you want information about programs that may help with your health care costs, you will need to answer questions about your income and resources. Any information you give is always kept private.

When you use the "Medicare Personal Plan Finder," you will get a personalized summary page with general information, like if the plan

covers outpatient prescription drugs, to help you compare plans in your area. You can also get detailed information, like what benefits are covered and how much you will pay for them. You can get this information about all the plans available in your area, or just the ones you are most interested in.

If you need help making your health plan choice, call your State Health Insurance Assistance Program (SHIP). The number for your State is listed in the *Medicare & You* handbook. Or, call 1-800-MEDICARE for the SHIP phone number in your State. You can also find some SHIP Web addresses and telephone numbers on the Medicare Web site.

www.medicare.gov
(Select "Helpful Contacts.")

NOTE FOR PEOPLE WITH ESRD: If you have End-Stage Renal Disease (ESRD), or permanent kidney failure requiring dialysis or a kidney transplant, you usually cannot join a Medicare managed care plan or Medicare Private Fee-for-Service plan. However, you can stay in the plan you are in or join another plan offered by the same company, which usually means in the same State. Also, if you've had a successful kidney transplant, you may be able to join a plan. If you are in a plan and your plan leaves Medicare or no longer provides coverage in your area, you can join another Medicare managed care plan or Medicare Private Fee-for-Service plan if one is available in your area. (This is true for people whose plans left Medicare or stopped providing coverage in their area on or after December 31, 1998.) Call 1-800-MEDICARE (1-800-633-4227) for more information about End-Stage Renal Disease and Medicare health plans.

Step 2. Find out which Medicare health plans are available in your area.

In some areas, only the Original Medicare Plan is available. But in some areas, there are other Medicare health plan choices. Here are two ways to learn what plans are available in your area:

- Look on the Medicare Web site. If you do not have a computer, your local library or senior center may be able to help you find this information on their computers. The new "Medicare Personal Plan Finder" helps you narrow down your Medicare health plan choices and choose the plan that's best for you.

  www.medicare.gov
  (Select "Medicare Personal Plan Finder.")

- Call 1-800-MEDICARE; then select option "0."

  ☎ 1-800-MEDICARE (1-800-633-4227)
  (24 hours a day, 7 days a week)

  1-877-486-2048 (toll-free)

Step 3. Call the plans you are most interested in and ask questions.

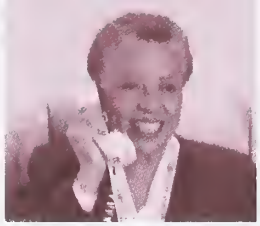
Medicare health plans differ in cost, choice of doctors and hospitals, and extra benefits like prescription drugs. Check to make sure the plan offers the service you need, their doctors and hospitals are easy to get to, and their offices are open when you need them. It is important to find out as much as you can about where you will get your health care before you choose a health plan.

Make a list of Medicare health plans in your area that you are interested in joining. Then call the plans and ask questions. You can also ask them to send you more information about the plan, called a Summary of Benefits. Compare the information you get to see which plan best meets your needs.

On the next few pages, there are some questions you may want to ask when you call. If you think of others, write them in the space at the bottom of the last page.

Questions To Ask When You Call Health Plans

	Plan 1	Plan 2	Plan 3
ABOUT COSTS, DOCTOR CHOICE, AND CONVENIENCE			
Will I pay an extra premium in addition to my Part B premium? If so, how much? How often?			
Will I have a copayment for doctor visits? If so, how much?			
Does the plan pay a maximum amount for certain services? If so, which services? How much?			
Will I pay a deductible or copayment for: Services in the hospital? Home health care? Skilled nursing care?			
How soon can I see a doctor? Do I need to notify the plan first or get a referral to see a specialist?			
Are doctors' offices located close to me?			
Are doctors' offices open at night and on weekends?			



	Plan 1	Plan 2	Plan 3
Is there a telephone "hotline" for medical advice?			
Where would I get lab work done?			
If the plan is a Medicare managed care plan, also ask: What doctors and hospitals are in the plan? (Check to see if your doctor is in the plan if you want to keep seeing him or her.)			
Can I see the doctor I want? If so, is he/she accepting new patients under that plan?			
Can I see the same doctor on most visits?			
Can I change doctors once I am in the plan?			
How can I see a specialist?			
Can I choose which specialist I want to see?			
What if the plan does not have the type of specialist I need?			
Will I pay more if I use doctors or hospitals outside the plan? If so, how much?			

	Plan 1	Plan 2	Plan 3
If the plan is a Medicare Private Fee-for-Service plan, also ask:			
Does the doctor I want to see know and accept the terms of the plan's payment?			
Does the plan set limits on how much doctors and hospitals can charge me for services?			
Does the plan require "pre-notification" if I go to: A hospital? A skilled nursing facility?			
ABOUT EXTRA BENEFITS LIKE PRESCRIPTION DRUGS			
Does the plan cover: Routine physical exams?			
Eye exams and eyeglasses?			
Hearing exams and hearing aids?			
Dental exams and dental treatments?			
Respite care, adult day care, or caregiver services?			
Wellness programs like nutrition counseling and help to stop smoking?			

	Plan 1	Plan 2	Plan 3
Programs that help members with specific chronic health problems, like asthma, diabetes, or heart conditions? Other benefits?			
Does the plan cover prescription drugs? If yes: Does the plan only pay for some prescription drugs and not others? If so, how do I find out if mine are covered?			
May I use my regular pharmacy?			
Are mail-order prescriptions available?			
Is there a maximum dollar limit on what the plan will pay for my prescription drugs each year? If so, how much?			
Will I pay more if I use a brand-name drug instead of a generic drug?			

Other questions to ask when I call:

Step 4. Find out how the plans rate in quality of care.

Quality health care means doing the right thing, at the right time, in the right way, for the right person—and having the best possible results. To help patients get the best quality of care, Medicare has certain standards for Medicare health plans and providers. For example:

- All Medicare doctors must be licensed in the States where they practice.
- The Medicare program certifies hospitals, nursing homes, and suppliers.
- Medicare managed care plans and Medicare Private Fee-for-Service plans must meet State and Federal Government standards.
- Medicare managed care plans must have a program to assure quality of care before they can get a Medicare contract.

Beyond these basic standards, the quality of care in plans may vary. To check up on quality, Medicare gets information each year from people in Medicare about how satisfied they are with their plans. Medicare also collects information every year on the services the plans give their members (like flu shots and diabetes monitoring). You can use quality information to help you make your health plan choice.

The Medicare Web site gives information for more than 10 different quality measures of how well a plan keeps its members healthy and treats them when they are sick and how satisfied members are with the care they get. You can find out the percentage of people who chose to leave their Medicare managed care plan during the year and, starting in late 2001, the reasons they left. You can also get this information by calling 1-800-MEDICARE.


www.medicare.gov
(Select "Medicare Health Plan Compare.")

☎ 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

Here are some other ways you can see how the Medicare health plans in your area rate in quality:

- Ask your family members, friends, and other people you know who are in Medicare health plans if they are satisfied with the care they get.
- Call your local office of consumer affairs and ask if they have information on the quality of Medicare health plans in your area.
- Call your State insurance department or your State health department. Ask if you can get information on the quality of Medicare health plans in your area.

For more information about plan quality, see Section 2.

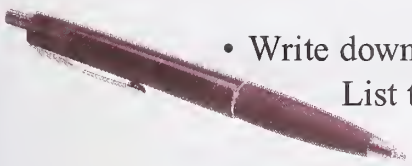
Step 5. Visit or call the doctors' offices where you would get your care.

Before you make a final decision about which Medicare health plan to choose, you may want to visit or call the doctors' offices where you would go to get your health care if you joined this plan. You may want to make an appointment to talk to someone before you visit.

Some Medicare managed care plans have their own health centers or office buildings where doctors, labs, and other services are located in a single place. Ask if you can see these when you visit. Other plans may refer you to an independent lab or another office for other services.

Here are some tips to help you get ready for your visit:

- Talk to your doctor about your health plan choice.
- Go over any information you have already gotten about the plan.



- Write down any questions you may have about the doctor's office. List the most important ones first. This will help to make sure you ask these questions when you visit or call.

After your visit or call, ask yourself the following questions:

- Did the staff treat patients with respect? Yes ___ No ___
- Did I feel comfortable? Yes ___ No ___
- Was the office clean? Yes ___ No ___
- Are the hours and location convenient? Yes ___ No ___

Step 6. Review your plan choices every year in the fall.

Medicare health plans can join or leave Medicare each year. They can also change their costs and extra benefits. Fall is a good time to think about health coverage for the coming year. Medicare + Choice plans accept new members each November. Make sure you know what coverage you have.

Check to see that your plan still covers your health care and financial needs. If not, you can look into other ways to get your health care. Repeat the steps to choosing a Medicare health plan to be sure you are in the best plan for you.

Joining a Medicare Health Plan

If you are in the Original Medicare Plan and want to stay in it, you do not have to do anything.

If you want to join a Medicare managed care plan or a Medicare Private Fee-for-Service plan:

- Call the plan and ask for an enrollment form.
- Complete the form and mail it to the plan, or give it to the plan representative.

- The plan will send you a letter telling you when your coverage begins.

Most Medicare health plans must accept new members during November of each year. They may also accept members at other times of the year. Some plans limit the number of members in their plans. A plan can tell you if it is signing up new members when you call.

Things To Remember

- **No matter what Medicare health plan you choose, you are still in the Medicare program.**
- **If you are in a Medicare + Choice plan, you must continue to pay the monthly Part B premium ($50 in 2001).**
- **All Medicare + Choice plans agree to stay in the Medicare program for a full year at a time. Each year the plans decide whether to stay in the Medicare program for another year.**
- **If you leave a Medicare health plan, you will not lose health coverage. You can choose another Medicare + Choice plan if one is available, or you can get care from the Original Medicare Plan. (See "Switching Medicare Health Plans" on page 23.)**
- **You must pay any additional premium the Medicare + Choice plan charges to remain in the plan.**
- **In most Medicare managed care plans, you must go to doctors and hospitals that belong to your plan.**
- **In a Medicare Private Fee-for-Service plan, you can go to any doctor or hospital that accepts the payment terms of the plan.**

Switching Medicare Health Plans

In 2001, you can leave (disenroll from) a Medicare + Choice plan at any time for any reason.

Starting January 1, 2002, you can leave a Medicare + Choice plan and join another plan only one time from January 1 through June 30, 2002. The plan must be accepting new members. In November 2002, you will have another chance to switch plans. If you switch plans in November 2002, the change will be effective January 1, 2003.

Starting January 1, 2003, the rules will change. You can leave a Medicare + Choice plan and join another plan only one time from January 1 through March 31, 2003. The plan must be accepting new members. Just like in 2002, you will have another chance to switch plans in November. Any change made in November will be effective the following January.

There are some exceptions to these rules. For more information on leaving a Medicare health plan, read *New Rules for Switching Medicare Health Plans* (CMS Pub. No. 02241). To order a free copy, visit the Medicare Web site or call 1-800-MEDICARE.

If you leave a plan, you are automatically returned to the Original Medicare Plan unless you join another Medicare + Choice plan (if one is available in your area).

If you want to leave your plan, write to the plan and tell them you want to disenroll. The plan will send you a letter with the date your coverage ends. You can also leave your plan by calling 1-800-MEDICARE and talking to a customer service representative, or by calling the Social Security Administration (SSA).

www.medicare.gov
(Select "Publications.")

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(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

Your Medicare Patient Rights

If you have Medicare, you have certain guaranteed rights. You have these rights whether you are in the Original Medicare Plan, a Medicare managed care plan, or a Medicare Private Fee-for-Service plan. They include the right to certain information, emergency care, appeals, treatment choices, and privacy. If you are in a Medicare managed care plan or a Medicare Private Fee-for-Service plan, you have additional rights, like the right to culturally competent services and the right to file a grievance.

You can find more information on your patient rights by reading *Your Medicare Rights and Protections* (CMS Pub. No. 10112). To order a free copy, visit the Medicare Web site or call 1-800-MEDICARE.

 www.medicare.gov
(Select "Publications.")

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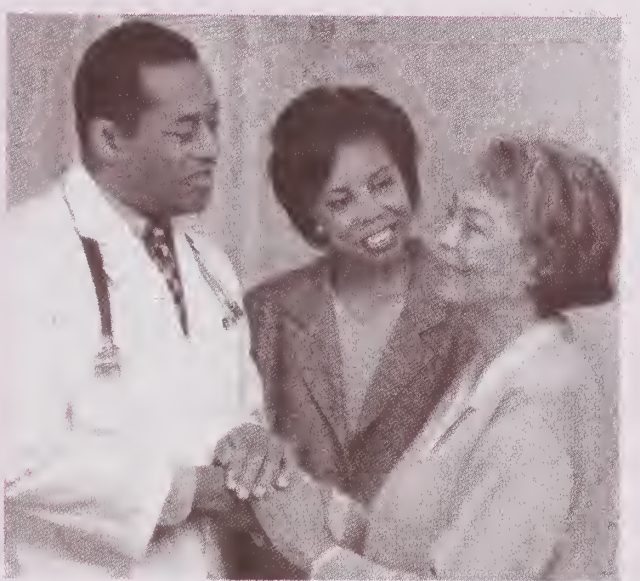
Section 2

If You Want To Know More



This section has more detailed information on choosing a Medicare health plan, including:

- Quality Information From Medicare and Other Groups
- Medigap Policies
- Other Types of Coverage
- Where To Get More Information

More Words You Should Know

Accredited (accreditation). Having a "seal of approval." Being accredited means that a facility or health plan has met certain quality standards. These standards are set by private, nationally recognized groups that check on the quality of care of health care facilities and organizations. Organizations that accredit Medicare managed care plans include the National Committee for Quality Assurance, the Joint Commission on Accreditation of Healthcare Organizations, and the American Accreditation HealthCare Commission/URAC.

Medigap policy. A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in Original Medicare Plan health coverage. Except in three States, there are 10 standardized Medigap policies labeled Plan A to Plan J. These policies only work with the Original Medicare Plan.

Performance measure. Information that shows how well a health plan provides a certain treatment, test, or other health care service to its members. For example, Medicare uses performance measures from NCQA's Health Plan Employer Data and Information Set (HEDIS®) to get information on how well health plans perform in quality, how easy it is to get care, and members' satisfaction with the health plan and its doctors.

Report card. A way to check up on the quality of care delivered by health plans. Report cards provide information on how well a health plan treats its members, keeps them healthy, and gives access to needed care. Report cards can be published by States, private health organizations, consumer groups, or health plans.

Quality Information Reported by Medicare

Medicare collects quality and satisfaction information from Medicare health plans and people with Medicare and reports this back to you. This information can be used to help you choose a health plan. An explanation of the information, and where to get it is listed below.

Surveys of Members' Experiences and Satisfaction With Health Plans

Every year the Medicare program does a survey of people in Medicare health plans to find out how satisfied they are with their plans. This survey is called the Medicare Consumer Assessment of Health Plans Survey (CAHPS®). The survey asks how people with Medicare rate their health plans and the health care they got in the last 6 months. The survey asks questions like "Did your doctors explain things in a way you could understand?" and "Was it easy to get a referral to a specialist?"

Starting in late 2001, Medicare will also report this information for people in the Original Medicare Plan.

CAHPS® was designed by national experts in health care quality, under a project funded by the Agency for Healthcare Research and Quality.

How Well Health Plans Meet Quality Standard of Care

Health plans send Medicare quality information on the health care they give using the Health Plan Employer Data and Information Set (HEDIS®). This is a special way to gather quality information, often called "performance measures." Medicare carefully checks this information for accuracy.

HEDIS® has information like the percent of women who get a mammogram (breast x-ray) and whether health care providers stay in the plan. You may find that two health plans have the same benefits at the same cost, but one may have higher ratings on some quality information than the other.

HEDIS® is sponsored by the National Committee for Quality Assurance, which is a private, not-for-profit organization.

Members Leaving and Staying With Health Plans

Medicare gets information from Medicare managed care plans and can tell the percentage of plan members who chose to leave their health plan. The information does not include members who died, moved out of the area, were not eligible for managed care under Medicare, or whose plan decided not to serve people with Medicare in that area.

By 2002, Medicare will report information from the Medicare Consumer Assessment of Health Plans Disenrollment Survey. The survey tells why people chose to leave their Medicare managed care plan by asking questions like "Did you have problems getting the care you needed?" or "Have you had problems with the plan doctors or other health care providers?"

Results of Staying in a Health Plan (starting in 2002)

The Health Outcomes Survey (HOS) tells how good a job Medicare health plans do, over time, in taking care of their members. The HOS uses information reported by Medicare plan members to measure how people feel (emotional health) and what they are able to do (physical health). By comparing whether plan members felt better, stayed the same, or felt worse physically and emotionally, the HOS tells us how well these health plans are taking care of their patients.

You can get Medicare quality information by using the Medicare Web site or calling 1-800-MEDICARE.

 www.medicare.gov
(Select "Medicare Health Plan Compare.")

 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

Other Sources of Health Plan Quality Information

There are many other sources of information on the quality of care given by health plans. You can use this information to help in choosing a Medicare health plan. Some of these sources are listed below. If you don't have a computer, your local library or senior center may be able to help you find the information on their computers.

NCQA's Health Plan Report Card

The National Committee for Quality Assurance (NCQA) evaluates and rates managed care plans, including Medicare managed care plans. NCQA sets the standards for the quality of care that health plans give their members. Accreditation of a health plan by the NCQA is a nationally recognized seal of approval.

NCQA's "Health Plan Report Card" provides quality information on various performance measures that show how well a health plan performs according to NCQA standards. Using the database on NCQA's Web site, you can create a report card that gives results on how well a plan keeps its members healthy or treats them when they are sick.

 www.NCQA.org
(Select "Health Plan Report Card.")

Quality Check™

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) evaluates and accredits over 20,000 health care organizations, hospitals, programs, and plans. JCAHO standards focus on areas that are most likely to improve patients' health, like preventive services to keep you healthy and making it easy to get care.

The JCAHO Web site includes "Quality Check™." You can find out if the health plan you are considering is accredited by JCAHO by using Quality Check™. Quality Check™ also has reports with information on the organization's overall performance and how it compares to others in specific areas.

Joint Commission on Accreditation of
Healthcare Organizations
One Renaissance Blvd.
Oakbrook Terrace, IL 60181

www.jcaho.org

630-792-5800

American Accreditation HealthCare Commission/URAC

The American Accreditation HealthCare Commission/URAC develops accreditation standards and programs for Medicare managed care plans as well as for other managed care organizations. You can get an alphabetical list of these organizations on the Commission's Web site. Or you can ask for a copy to be mailed to you.

American Accreditation HealthCare Commission/URAC
1275 K Street NW, #1100
Washington, DC 20005

www.urac.org

202-216-9010

State Quality Reports

Some States publish reports on how well health plans in the State give care to their members and how satisfied people are with the care they get. Below are three examples. Call your local library and ask whether your State publishes any reports on the quality of care of health plans available in your area.

- **Maryland.** The Maryland Health Care Commission publishes reports on how well managed care plans in Maryland provide services to keep their members healthy and how easy it is to get care when they are sick. To learn more:

  
  www.mhcc.state.md.us
  (Select "HMO Quality & Performance.")

- **New Jersey.** The New Jersey Department of Health and Senior Services publishes report cards for HMOs and point of service plans in New Jersey. You can read these reports on the Web site. You can also compare the performance of specific plans. To learn more:

  
  www.state.nj.us/health
  (Select "Consumer Report Cards." Then select "NJ HMOs Performance Reports.")

- **Pennsylvania.** The Pennsylvania Health Care Cost Containment Council (PHC4) publishes reports on the quality of Pennsylvania HMOs. One of these reports is on the role of HMOs, including Medicare HMOs, in managing diabetes. To learn more:

  
  www.phc4.org
  (Select "Health Plans.")

Medigap (Medicare Supplement Insurance) Policies

Medigap (Medicare supplement insurance) policies are sold by private insurance companies. This type of policy is called "Medigap" because it covers some of the gaps in Original Medicare Plan coverage. These gaps include:

- Medicare coinsurance and copayment amounts
- Medicare deductibles
- Items and services not covered by Medicare

Premiums for Medigap policies vary by State and by insurer. Premiums may be different depending on your age and the way companies price their policies. You pay a monthly premium for the policy, in addition to the monthly Medicare Part B premium.

With most Medigap policies, you can go to any doctor or hospital that accepts Medicare. In the type of Medigap policy called "Medicare SELECT," you must use the plan's hospitals, and in some cases the plan's doctors, to get full Medigap benefits.

For more information on Medigap policies, look in the *2001 Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy* (CMS Pub. No. 02110). You can order a free copy from the Medicare Web site or by calling 1-800-MEDICARE. You can also select "Medigap Compare" on the Medicare Web site to compare the Medigap policies available in your area.

 www.medicare.gov

 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

 1-877-486-2048 (toll-free)

Your State Health Insurance Assistance Program also has information on Medigap policies. The telephone number for your State is listed in the *Medicare and You* handbook.

Finding Out About Other Types of Coverage

You may be able to get other types of health care coverage besides Medicare:

- You may be able to get health care coverage from your employer or union if you (or your spouse) are still working. Even if you are retired, you may be able to get health care coverage based on your previous employment. Check with your employer or union to see if you qualify. Talk to your benefits administrator before you make any health plan decisions.

- If you have limited income and assets, you may qualify for help from your State to pay some health care costs. Call your State medical assistance office for more information on these programs. You can get the phone number on the Medicare Web site or by calling 1-800-MEDICARE.

   www.medicare.gov
  (Select "Helpful Contacts.")

   1-800-MEDICARE (1-800-633-4227)
  (24 hours a day, 7 days a week)

   1-877-486-2048 (toll-free)

- If you are a veteran or military retiree, you may be eligible to get health care benefits based on your military service. If you are a veteran, call the U.S. Department of Veterans Affairs (VA) for more information. You can also find out about veterans' benefits and services on the VA Web site.

   www.va.gov
  (Select "Health Benefits & Services.")

☎ 1-877-222-VETS (1-877-222-8387)

If you or your spouse are retired from military service, call about TRICARE For Life or visit the TRICARE For Life Web site.

 www.tricare.osd.mil

☎ 1-888-DOD-LIFE (1-888-363-5433)

Getting More Information

More information is available to help you make your health plan choice. Some free booklets can be ordered, and some information is on the Web. If you do not have a computer, your local library or senior center may be able to help you find the information on their computers.

Medicare Information

Many booklets can be ordered from the Medicare Web site and by calling 1-800-MEDICARE. These free booklets explain Medicare benefits, coverage, rights, health plan choices, and more. A few examples are listed below.

- *Your Guide to Private Fee-for-Service Plans.* (CMS Pub. No. 10144)
- *Medicare Savings Programs.* (CMS Pub. No. 10126)
- *Your Medicare Rights and Protections.* (CMS Pub. No. 10112)
- *2001 Guide to Health Insurance for People with Medicare: Choosing a Medigap Policy.* (CMS Pub. No. 02110)

 www.medicare.gov
(Select "Publications.")

☎ 1-800-MEDICARE (1-800-633-4227)
(24 hours a day, 7 days a week)

1-877-486-2048 (toll-free)

The Medicare Web site lets you get detailed information on Medicare health plans, Medigap policies, nursing homes, and dialysis facilities by State or ZIP Code. You can use the "Medicare Personal Plan Finder" to help you locate and compare health plans in your area. You can also find information on programs that offer help in buying prescription drugs and a list of doctors and suppliers in your area who accept Medicare.

www.medicare.gov
(Select "Medicare Personal Plan Finder" for health plans, "Medigap Compare" for Medigap policies, "Nursing Home Compare" for nursing homes, "Dialysis Facility Compare" for dialysis facilities, "Prescription Drug Assistance Programs" for drug assistance programs for individuals in need, "Participating Physician Directory" for Medicare participating physicians, and the "Participating Supplier Directory" for Medicare participating suppliers.)

AHRQ Publications Clearinghouse

This service of the Agency for Healthcare Research and Quality (AHRQ), part of the Federal Government, offers these free brochures to help you choose a health plan.

- *Your Guide to Choosing Quality Health Care.* 47 pages. (AHCPR 99-0012)

- *Choosing and Using a Health Plan.* 29 pages. (AHCPR 97-0011)

AHRQ Publications Clearinghouse
P.O. Box 8547
Silver Spring, MD 20901

www.ahrq.gov
(Select "Health Plans.")

☎ 1-800-358-9295

AARP Consumer Resources

The American Association of Retired Persons (AARP) has many free brochures on health insurance and how to choose and use a Medicare health plan. Some are listed below. The AARP Web site lists other resources. Order by publication number.

- *Checkpoints for Managed Care: How to Choose a Health Plan* (D16342)
- *Making Medicare Choices* (D16747)
- *Selecting Medicare Supplemental Insurance* (D16813)
- *9 Ways to Get the Most From Your Managed Health Care Plan* (D16615)

✉ American Association of Retired Persons
611 E Street NW
Washington, DC 20049

 www.aarp.org
(Select "Health and Wellness.")

☎ 1-800-424-3410

Guide to Health Insurance

This free booklet from the Health Insurance Association of America summarizes different kinds of health insurance plans and answers frequently asked questions about health plan coverage.

✉ Health Insurance Association of America
1201 F Street NW, Suite 500
Washington, DC 20004-1204

 www.hiaa.org
(Select "Consumer Information.")

☎ 202-824-1600

Putting Patients First

This guide from the National Health Council lists where you can get information for 170 conditions and diseases and includes a short consumer's checklist for evaluating health plans.

 National Health Council
1730 M Street NW, Suite 500
Washington, DC 20036-4505

☎ 202-785-3910

Healthfinder

The healthfinder Web site, run by the U.S. Department of Health and Human Services, offers reliable consumer information from the Federal Government and its many partners. It has links to Web sites with consumer health information, online publication catalogs, and online brochures that help you find information on the Web.

 www.healthfinder.gov

How to Choose a Health Plan

The American Association of Health Plans (AAHP) Web site gives tips for consumers on gathering information for choosing a managed care health plan.

 www.aahp.org
(Select "For Consumers." Then select "How to Choose a Health Plan.")

Health Pages

Health Pages is a commercial Web site with articles for consumers on many health care topics, including how to choose a health plan.

- *Your Complete Guide to Managed Care.* 15 pages.
- *Medicare and the Managed Care Option.* 7 pages.
- *Medicare: Bridging the Gaps.* 15 pages.

You can read or print these articles from your computer. You can also review and compare managed care plans, including Medicare managed care plans, online by State and county.

 www.thehealthpages.com

HealthScope

The HealthScope Web site, from the Pacific Business Group on Health, offers information on using quality report cards and other information to choose a health plan. It includes ratings of HMOs in California.

 www.healthscope.org
(Select "Health Plans.")

NOTES

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U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services
(Formerly the Health Care Financing Administration)
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Official Business
Penalty for Private Use $300

Publication No. CMS-02219
September 2001

This booklet, ***Choosing a Medicare Health Plan***, is one of a new series of booklets for people who have Medicare. Other titles include ***Choosing a Doctor, Choosing Treatments, Choosing a Hospital,*** and ***Choosing Long-Term Care***, which will be available in late 2001. Each booklet can help you to make health care choices. Use this booklet to help you decide how to get your Medicare health care.

To get copies of this booklet in print (English or Spanish) or Braille, call 1-800-633-4227, TTY/TDD: 1-877-486-2048 for the hearing and speech impaired.

Agency for Healthcare Research and Quality